TDI 1-WEB

Rhode Island Department of Labor and Training

TEMPORARY DISABILITY INSURANCE DIVISION

PO BOX 20070, Cranston RI 02920-0941
Telephone (401) 462-8420 Hearing Impaired (TDD) (401) 462-8464 and Fax (401) 462-8466

APPLICATION FOR BENEFITS

Please print neatly.

PERSONAL INFORMATION

1. Name First MI Last	2. Your Social Security Number
3. Mailing Address Apt. No.	4. Home Address (if different from mailing address) Apt. No.
City & State Zip Code	City & State Zip Code
5. Date of Birth (Month/ Day/Year)	6. Telephone Number 7. Male ☐ Female ☐

8. What is your usual job?

9. Check the days of the week you normally work. Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐

10. Have you applied for or received TDI Benefits in the last 12 months? Yes ☐ No ☐

11. Have you applied for or received Unemployment Benefits in the last 12 months? Yes ☐ No ☐

DISABILITY INFORMATION

12. What is your disability?

13 Date you last worked before this disability began?

14. First day you were unable to work because of this disability?

15 Date you were first examined for this disability?

16 Date of your most recent examination for this disability?

17. If you have recovered and/or returned to work since this disability began enter date(s) below.

Date recovered: Date returned to work:

18. Is this disability work related? Yes ☐ No ☐ If "NO", Go to Page 2.

WORK RELATED DISABILITIES (complete only if this disability is work related)

19. Have you filed a Workers' Compensation Claim for this disability? Yes ☐ No ☐

If NO, Please explain why not:

20. If YES, Please give the name and address of the Workers' Compensation Insurance Company.

21. If you have a lawyer representing you in this matter, give his/her name and address.

22. Have you received ANY Workers' Compensation payments for this disability? Yes ☐ No ☐

If YES, For what period were you compensated? FROM: TO:

office use	DEP	PHYS	PHYS	SE	WC	UI	BYB	BYE

MEDICAL INFORMATION (if you need more space add a separate sheet.)

23A. Physician's Name If clinic patient, name hospital

DR.

Address

City State zip Telephone Number

23B. Physician's Name If clinic patient, name hospital

DR.

Address

City State zip Telephone Number

24. Were you hospitalized for this disability? YES ☐ NO ☐ If "YES" complete the remainder of this section.

Name of Hospital	Date Admitted:
Address	Date Discharged:
City, State, Zip	Patient Number, if known:

EMPLOYMENT RECORD (If you need more space add a separate sheet.)

PRINT the name and address of all your employers during the past 2 years, even if you have submitted a claim for TDI benefits in the past year. Please be sure all addresses and ZIP codes are correct.

25A. Name of most recent or present employer	25C. Name of employer
Address	Address
City, State, Zip	City, State, Zip
Telephone Number	Telephone Number
Was your work performed in RI? Yes ☐ No ☐	Was your work performed in RI? Yes ☐ No ☐
Employed From: To:	Employed From: To:
Office Use	Office Use
25B. Name of employer	25D. Name of employer
Address	Address
City, State, Zip	City, State, Zip
Telephone Number	Telephone Number
Was your work performed in RI? Yes ☐ No ☐	Was your work performed in RI? Yes ☐ No ☐
Employed From: To:	Employed From: To:
Office Use	Office Use

26. In your present employment, are you also a corporate officer? Yes ☐ No ☐ Your SSN:

27. List beginning and ending dates of any period of self-employment during the past two years: FROM TO

DEPENDENCY ALLOWANCE

28 How many children under age 18 are dependent upon you? (Include children 18 and older who are handicapped)

29 Do all the children counted in #29 live with you? YES ☐ NO ☐

30 Is any other person claiming your children as dependents under the Rhode Island Temporary Disability Act? YES ☐ NO ☐

31. If "YES" List name, address and Social Security Number of person claiming such children.
NAME SOCIAL SECURITY NUMBER ADDRESS

32. List below only the names of dependents who are your OWN NATURAL, ADOPTED, STEP children or court appointed wards. Do not include nieces, nephews, grandchildren, etc. Please include a Social Security Number for all children over one year old, OR provide other evidenceof dependency status (for example, copies of birth certificates, adoption documents, etc.).

Name of Child	Birth Date	Social Security No. If First Last Child is over 1 year old.

33 If any child name above is 18 or older, indicate type of incapacity mental or physical.

34.

I certify that I am/was physically unable to work during the period for which I am claiming benefits and that the information that I have provided on this application is true and complete. I also authorize my physician to disclose all necessary information to the TDI division.

SIGNATURE _____ Date _____

MEDICAL INFORMATION RELEASE FOR RHODE ISLAND TEMPORARY DISABILITY INSURANCE

35. *I hereby authorize my physician, hospital or other health care provider to make available to the Rhode island Temporary Disability insurance Division any medical information, including hospital records, which may be requested. I agree that a photocopy of this release be as valid as the original.*

Your Signature *Social Security Number* *Date*

REQUEST FOR DIRECT DEPOSIT

DO NOT COMPLETE THIS SECTION UNLESS YOU WANT DIRECT DEPOSIT!

36. Temporary Disability Insurance is usually paid by check. If you desire, you may have your payment(s) electronically deposited into your existing savings *or* checking account. *This is an option not a requirement.*

Direct deposit is offered only as a possible convenience to you. It will NOT speed up the actual payment of your TDI benefits. It may take as long as three weeks to complete the necessary arrangements with your bank. If any TDI benefits are due before these arrangements are completed, you will be paid by check(s) sent to your mailing address. Also, if your bank is at any time unable to process your direct deposit transaction, a check will be automatically sent to your mailing address.

To elect direct deposit, you must provide all the Bank Information requested. You will probably have to contact your bank to obtain the bank's Routing Number. After you have entered all the information needed, be sure to sign this request on the line below.

Name of Your Bank:	Your SSN:
Bank Account Type (Check One):	Checking ☐ Savings ☐
Bank Account Number:	
Bank Routing Number:	

I hereby authorize the Rhode Island Department of Labor and Training to directly deposit my Rhode Island Temporary Disability Insurance payment to the bank account designated on this application.

Your Signature _____ Date _____

BEFORE MAILING! . . . **Be Sure Your Social Security Number Appears on All Pages**

Have you completely answered all questions?
Is your Social Security Number correct?
Have you signed the application form (Item 34?
Did you list all doctors and/or hospitals who have treated you for this period of disability?
Did you list all your employers for the past two years?
If you want Direct Deposit, did you sign authorization (Item 36)?

REMEMBER! . . .

You cannot be employed and collect TDI for the same period.
You cannot collect TDI and unemployment insurance for the same period

Mail your completed application to:

Temporary Disability Insurance Division
RI Department of Labor and Training
PO BOX 20070
Cranston, RI 02920-0941

OR fax it to: (401) 462-8466

Note: When your application has been entered into our automated system, we will mail an acknowledgement form to you. However, if your application is incomplete and cannot be corrected via a telephone call, then the application will be mailed back to you in order to get complete information.